471-000-95 Instructions for Completing Form MC-73, "Time Assessment and Service Plan"

Use: Form MC-73, "Time Assessment and Service Plan," is completed by local office staff with the client during an interview to determine eligibility for personal assistance services. The Social Services Worker or designee must interview the client and/or guardian by telephone or in person. The client and/or guardian must be an integral part of the development of the assessment and service plan by stating their service needs and preferences, and jointly determining the time to be authorized.

Completion: Local office staff completes all sections of Form MC-73 as follows:

Section I

Enter the client's name, Medicaid number, guardian's name (if applicable), and contact information.

Section II

Check all eligibility criteria that apply. All must be checked for client to be eligible for Personal Assistance Services (PAS).

Section III

1. Determine the client's specific needs for PAS by asking the client and/or guardian to identify the tasks.
2. Ask the client and/or guardian about other services being received.
3. Utilizing the list of specific tasks identified, and together with the client and/or guardian, determine the time each activity will reasonably require.
4. Specialized Procedures require Form MILTC-4D for health maintenance activities.
5. Supportive Services may be added only as a supplement, not as the only category of services being provided
6. Determine the total amount of time to be authorized for PAS based on the joint determination of needed tasks and time required.

Section IV

1. Together with the client and/or guardian, discuss the client's preference for a provider. If there is a preference of provider(s), include the name(s) on the service plan.
2. Suggest the client and/or guardian have arrangements for an alternative provider for emergencies.
3. Form MC-73 is signed by the Social Services Worker or designee and the client or guardian. If the interview is by telephone, the form is mailed for his/her signature.

Distribution: Local office staff retains the white original of Form MC-73. The client receives a yellow copy and the provider receives a pink copy.

Retention: The local office staff retains Form MC-73 as a permanent part of the client's case record.

TIME ASSESSMENT AND SERVICE PLAN

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

SECTION I:

Client:	Medicaid#:
Guardian (if applicable):	
Contact Information:	

SECTION II: Check all that apply. All must be checked for client to be eligible for Personal Assistance Service (PAS).

- ☐ 1. Is a current Medicaid client;
- ☐ 2. Needs personal assistance services to live in the community;
- ☐ 3. Does not have needs that require more intensive services due to an acute health care level;
- ☐ 4. Is not receiving or eligible for PAS or similar support based on residence or place of employment;
- ☐ 5. Lives in a residence not a hospital, nursing facility, intermediate care facility, prison, or other institution.

SECTION III: Discuss with client/guardian the needs for assistance and indicate the time needed for each task. Include explanation of any other services currently being provided to meet the needs in the area under "Special Instructions/ Comments". Also use "Special Instructions/Comments" to explain why additional time is needed beyond the estimated time frames. Please consider that some tasks may be completed at the same time.

Personal Assistance Service Needs	Estimated Time	Time Needed	Special Instructions/Comments
Nutrition			
☐ Needs meals prepared____x/day	15-30 minutes		
☐ Needs assistance with meal prep____x/day			
☐ Needs reminding to eat			
☐ Needs assistance with eating such as cutting meat____x/day	5 minutes		
☐ Needs to be fed____x/day	15-30 minutes		
☐ Needs meals prepared____x/day			
☐ Special diet	1 hour		
☐ Other			
Grooming/Hygiene			
☐ Bath/shower____x/wk	15-30 minutes		
☐ Dressing____x/day	15-20 minutes		
☐ Shampoo____x/wk	30-60 minutes		
☐ Shaving____x/wk	10 minutes		
☐ Hair grooming____x/wk			
☐ Oral care____x/day	5 minutes		
☐ Nail care____x/day	10 minutes		
☐ Assist w/TED Hose	10-15 minutes		
☐ Other			
Mobility			
Transfer:	15-30 minutes		
☐ Minimal Assistance			
☐ Moderate Assistance			
☐ Heavy Support/Lifting			
☐ Special Assistive Devices(specify)			
☐ Turn and Position in Bed			
Walking:	5-10 minutes		
☐ Minimal Assistance			
☐ Moderate Assistance	5 minutes		
☐ Heavy Support/Lifting	10 minutes		
☐ Special Assistive Devices(specify)			
Wheelchair Maneuvering:	up to 15 minutes each		
☐ Partial Assistance			
☐ Complete Assistance			
☐ Other			

Toileting/Bowel and Bladder Care ☐ Assist on/off toilet ☐ Cleansing on toilet ☐ Establish/maintain brief/diaper/bedpan routine ☐ Change/empty catheter bag ☐ Other	15-30 minutes		
Medications ☐ Assist with administration of medications ☐ Remind to refill prescriptions ☐ Other	5 minutes per task		
Specialized Procedures (health maintenance activities) ☐ Administration of injections _____ x/day ☐ Insertion of catheter _____ x/day ☐ Administration of oxygen _____ x/day ☐ Wound irrigation _____ x/day ☐ Application of dressings _____ x/day ☐ Check vital signs _____ x/day ☐ Other	5-10 minutes 15-30 minutes 15-30 minutes 15-30 minutes 30 minutes 15 minutes		☐ *Physician/RN Statement signed*
Supportive Services ☐ Laundry _____ x/wk Clean ☐ bathroom _____ x/wk ☐ kitchen _____ x/wk ☐ other living areas used by client _____ x/wk ☐ Make bed &/or change linens _____ x/wk ☐ Wash dishes _____ x/wk ☐ Remove trash _____ x/wk ☐ Shopping for groceries _____ x/wk ☐ Shopping for personal items, medications and other _____ x/wk ☐ Accompanying to appointments_____ x/wk ☐ Other	2 hours per week 30 minutes 15 minutes 15 minutes 5-10 minutes 10-15 minutes 5 minutes 1-3 hours/week 1/2 hour 1-3 hours		
TOTAL TIME*			

Prior authorization from Central Office is needed if total time will exceed 40 hours per week.

Section IV: Does the client have a preferred provider who is willing to provide the service? _____ Yes _____ No

Name:_____
Address:_____
Phone: _____

If so, is the provider already approved? _____ Yes _____ No

Completed by:_____ _____ _____ _____
Social Services Worker(or designee) Date Client Date

Distribution: WHITE COPY - Local Office; YELLOW COPY - Recipient; PINK COPY - Provider